

PRINTED: 10/26/2017
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4716	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2017	
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, FARRAGUT		STREET ADDRESS, CITY, STATE, ZIP CODE 120 CAVETT HILL LANE KNOXVILLE, TN 37922		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the annual licensure survey conducted on 10/23/17, no deficiencies were cited under 1200-08-06, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

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If continuation sheet 1 of 1